QUILEZ
FAMILY DENTISTRY AND ORTHODONTICS

We're so glad you're here. Please fill out the form below.

Patient Information

Full Name

Today's Date

Date of Birth

Age

Gender

Social Security Number

Marital Status

- ○ Single
- ○ Married
- ○ Widowed

Street Address

City

State

ZIP Code

Primary Phone

- ○ Home
- ○ Cell

Email Address

Preferred Language

- ○ English
- ○ Spanish
- ○ Other:

Employer / Occupation

Emergency Contact

Contact Name

Relationship

Phone

Reason for Your Visit

Tell us what's on your mind — dental concerns, pain, or anything you'd like us to know.

How did you hear about us?

Primary Insurance Information

Insurance Company

Employer

Policy Holder's Name

Policy Holder DOB

Policy Number

Group Number

Patient Relationship to Subscriber

Secondary Insurance Information (if applicable)

Insurance Company

Employer

Policy Holder's Name

Policy Holder DOB

Policy Number

Group Number

Patient Relationship to Subscriber

Preferred Pharmacy

Pharmacy Name

Phone

Street Address

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Company and assign directly to Dr. Quilez all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. This dental facility may use my healthcare information and disclose it to the named insurance company(ies) for the purpose of obtaining payment and determining benefits. This consent remains in effect as long as I am a patient here.

Print Name

Date

Signature

Relationship to Patient

This information helps us provide the safest, most comfortable care for you. All answers are confidential.

Primary Care Provider

Provider Name

Phone

Date of Last Physical

Reproductive Health

Are you currently taking birth control? ○ Yes ○ No ○ N/A

Are you currently pregnant or nursing? ○ Yes ○ No ○ N/A

Estimated due date (if applicable)

Medical & Surgical History

Prior hospitalizations or surgeries (please include dates):

Does the patient currently use alcohol, tobacco, or recreational drugs? ○ Yes ○ No

Dental History

Do you require antibiotics before dental procedures? ○ Yes ○ No

Date of Last Dental Visit

Date of Last X-Ray

Have you ever been treated for periodontal (gum) disease? ○ Yes ○ No

Have you ever had Novocain or other local anesthetic? ○ Yes ○ No

On a scale of 1–10, how happy are you with your smile? (1 = not happy, 10 = very happy)

Current Dental Concerns (check all that apply)

- ☐ Pain in Jaw (TMJ)
- ☐ Teeth Grinding / Clenching
- ☐ Tobacco Use
- ☐ Swollen / Bleeding Gums
- ☐ Mouth Sores
- ☐ Broken / Loose Teeth
- ☐ Sensitive Teeth
- ☐ Difficulty Chewing
- ☐ Crooked / Spaced Teeth
- ☐ Tooth Color / Appearance

Are you currently in pain? ○ Yes ○ No

Do you have fears or anxieties about dental treatment? ○ Yes ○ No

If yes, please tell us more:

Patient Name

Date

General Health

Steroid / cortisone therapy within the last 2 years	○ Yes	○ No
Require antibiotics before dental treatment	○ Yes	○ No
Use alcohol, tobacco, or recreational drugs	○ Yes	○ No

Allergies / Adverse Reactions (check all that apply)

☐ None	☐ Penicillin	☐ Amoxicillin	☐ Sulfa
☐ Aspirin	☐ Ibuprofen	☐ Codeine	☐ Latex
☐ Epinephrine	☐ Metals	☐ Tetracycline	☐ Erythromycin
☐ Other:			

Current Medications & Supplements

Medication / Supplement	Dosage / Frequency

Medical Conditions (please indicate Yes or No for each)

Asthma	○ Yes	○ No	Cancer	○ Yes	○ No
Diabetes	○ Yes	○ No	Stroke	○ Yes	○ No
Epilepsy / Seizures	○ Yes	○ No	Tuberculosis	○ Yes	○ No
Heart Disease / Attack	○ Yes	○ No	Heart Murmur	○ Yes	○ No
High Blood Pressure	○ Yes	○ No	Low Blood Pressure	○ Yes	○ No
Pacemaker	○ Yes	○ No	Artificial Heart Valve	○ Yes	○ No
Congenital Heart Disease	○ Yes	○ No	Kidney Trouble	○ Yes	○ No
Glaucoma	○ Yes	○ No	Arthritis / Rheumatism	○ Yes	○ No
Psychiatric Care	○ Yes	○ No	Thyroid Problems	○ Yes	○ No
Sinus Issues	○ Yes	○ No	Hay Fever / Allergies	○ Yes	○ No
Cold Sores	○ Yes	○ No	HIV / AIDS	○ Yes	○ No
Chemotherapy	○ Yes	○ No	Radiation Therapy	○ Yes	○ No
Ulcers	○ Yes	○ No			

General Consent to Treatment

General Consent

Initial:

I understand that dentistry is not an exact science and reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee has been made regarding the dental treatment I have requested. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Radiographs & Diagnostic Aids

Initial:

I authorize the dentist to use x-rays and other diagnostic aids for diagnosis and treatment planning. X-rays, photos, and models are property of the practice; copies are available upon request for a fee.

Drugs & Medications

Initial:

I understand that antibiotics, analgesics, and other medications can cause allergic reactions including redness, swelling, pain, itching, vomiting, and/or anaphylactic shock.

Changes in Treatment Plan

Initial:

I understand that during treatment it may be necessary to change or add procedures. I give permission to the dentist to make necessary changes after discussing them with me.

Fillings

Initial:

I understand care must be taken when chewing on new fillings, especially in the first 24 hours. Sensitivity is a common after-effect of a newly placed filling.

Local Anesthetic

Initial:

Anesthetic is injected to numb the area for treatment. Numbness typically lasts 2–3 hours. In rare cases numbness may be prolonged. Risks include infection, swelling, nausea, and cheek/lip biting.

Print Name

Date

Signature

Relationship to Patient

Appointment Policy

Thank you for choosing Quilez Family Dentistry and Orthodontics!
We look forward to caring for you and your family.

We reserve appointment times specifically for you and ask for at least **24 hours' notice** to reschedule. Last-minute cancellations affect you, our doctor, and waiting patients. **A late cancellation fee applies within 24 hours.** Fees subject to change.

Signature

Date

HIPAA Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you may access this information.

Our Legal Duty

Federal andstate law requires us to maintain the privacy of your health information and provide you with this notice. We reserve the right to update our practices and will make updated notices available upon request.

Treatment

We may use your health information for treatment, or share it with other providers involved in your care.

Payment

We may use and disclose your information to obtain payment for services provided to you.

Healthcare Operations

We may use your information for quality assessment, staff review, training, and credentialing activities.

Your Authorization

You may give written authorization to use or disclose your information. You may revoke it in writing at any time.

Family & Friends

We may share information with family or friends involved in your care and will give you the opportunity to object.

Appointment Reminders

We may contact you with reminders via voicemail, postcard, or letter.

Your Rights

You have the right to inspect and copy your health information, request corrections, restrict uses, and receive an accounting of disclosures. Contact our office for a full copy of our privacy notice.

Acknowledgement of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices and have had the opportunity to review it.

Print Name

Date

Signature

Parent / Guardian — complete below if patient is a minor

Print Name

Signature

Date